TRRx Request for Proposals Questions and Answers
4/22/03

NOTE: This set of Questions and Answers, originally posted April 11, 2003 is updated to provide responses to questions 107, 126, and 134. All other responses remain unchanged.

Question 101. ICD doc – page 72 – states that "The pricing submitted on TED file reflects the prices calculated by PDTS (e.g. Reduced to MCPFP pricing) except for those transactions where the MCPF price was overridden." Please describe MCPFP pricing & MCPF price.

Response 101. MCPF pricing does not apply to the TRRx contract. The ICD has been corrected. The pricing used by PDTS will be the price submitted in the claims transaction in accordance with the Contractor's network pharmacy agreement.

Question 102. ICD doc – page 22 – states that "It will be the TRRx responsibility to provide WEBMD with list on TRRx NCPDP pharmacy ID's." Will this be a one time list or an ongoing transaction? Please provide expected data elements and layout needed for this list and how this list will be accepted by WEBMD (CD Rom, etc.).

Response 102. The submission will be an on-going requirement. File structure and media format will be determined upon contract implementation.

Question 103. ICD doc – page 22 – states that "WebMd is going to provide 3 files to "Seed" TRRx records with "New Patient ID's". Please explain the intent of these files and provide expected data elements, layout for the file, and how the file will be transmitted.

Response 103. The ICD has been corrected to eliminate this requirement. Eligibility will be performed by PDTS in real time using the patient IDs provided in the on-line claims transaction.

Question 104. ICD doc – page 67 states "PDTS will edit TRRx dispensings against each other" and page 69 states "PDTS relies on TRRx to edit these overlaps." These statements are inconsistent. Please clarify if the contractor is responsible to edit their own transactions.

Response 104. The Contractor is not required to edit its own transactions. The ICD has been corrected.

Question 105. G.1.1.5.1 states "…the contractor shall transmit an electronic file to TMA/CRM of the payments issued against the bank account must be reported electronically…." Can we assume that this transaction will be in the HIPAA X.25 835 transaction format?

Response 105. No. This information shall be as specified in Section G.1.1.5.1.

Question 106. G.2.2 states "The ICN will be included in the TED record by PDTS and will be returned to the contractor for tracking and audit purposes." How will this ICN be communicated back to the contractor?

Response 106. The ICN will be included in the file sent to the Contractor by PDTS that identifies the TEDs submitted for payment to TMA.

Question 107. The explanations and definitions are different for Medical Necessity and Prior Authorization functions as defined in the RFP (C.11; C;12) compared to the statements in Section J, Attachment 12. Please clarify the differences. After reviewing the number of expected occurrences (for prior authorizations and medical necessity) compared to the total volume of transactions, what are the financial/non-financial goals of these functions?

Response 107. **(Response added April 22, 2003)** The explanations and definitions for Medical Necessity and Prior Authorization functions in Sections C.11 and C.12 of the RFP are consistent with the statements in Section J, Attachment 12. For example: Paragraph 1.1 of Attachment 12 states, "Examples of medical necessity determinations include: (1) whether medical necessity substantiates providing a beneficiary a non-formulary pharmaceutical agent or supply at the formulary co-pay; and (2) where prior authorization is required for a designated pharmaceutical, whether supporting documentation supports authorization of the pharmaceutical." These examples of medical necessity and prior authorization determinations are completely consistent with Sections C.11 and C.12 of the RFP. The goal of the medical necessity determinations is to accurately and efficiently determine whether a non-formulary drug should be provided at the formulary co-pay due to the medical necessity to use a non-formulary drug. The goal of the prior authorization function is to accurately and efficiently determine whether the proposed use of a pharmaceutical is consistent with the prior authorization criteria established for that drug by the DoD Pharmacy and Therapeutics (P&T) Committee. Additionally, the RFP refers to a process that is effective only for the initial determination level of review, whereas the appeals attachment describes the process beginning at the first level of appeal or the reconsideration level of review.

Question 108. The intent of the RFP is for TMA to get full benefit of all network discounts. We assume this prevents a bidder from getting a differential (or higher discount) that is not passed on to TMA?

Response 108. Your assumption is correct. See Section C.6.3.

Question 109. The last sentence of Section C.1.1. seems to imply that prescriptions filled by the retail pharmacy network would be eligible for Federal Supply Schedule (FSS) prices for the drug procurement cost, i.e. "Therefore, the DoD will be acquiring covered drugs and procuring them for the use of the Federal Government with DoD funds". Please describe the retail pharmacy reimbursement for product acquisition cost. Also, will pharmaceutical manufacturers be required to pay a "rebate" to the DoD in order to have their products reimbursed in the retail pharmacy network?

Response 109. Retail pharmacy reimbursement shall be in accordance with the network agreement in place between the contractor and the pharmacy. Network agreements must comply with RFP Section C.6. Rebates from pharmaceutical manufacturers to the Government are not applicable to this solicitation.

Question 110. For government programs, such as TRICARE, if an offeror performs claims processing and customer service functions for a contract that includes pharmacy services, we believe this would constitute relevant experience to be addressed in Past Performance. If, for that same offeror's commercial business, they subcontract all Pharmacy Benefit Management services to a third party vendor we do not believe this satisfies the government's intent and would subject the government evaluators to large volume of commercial experience that would not help in a true comparison of how the offeror would perform on this procurement. Do you agree with our assumption that such subcontracted PBM services should not be included in Past Performance?

Response 110. No, we do not agree with your assumption. Relevant past performance history is defined as performance history involving the actual performance of significant elements of a Pharmacy Benefit Manager, to include, but not limited to, pharmacy claims processing, pharmacy network development and management, prior authorization of pharmacy prescriptions, and medical necessity determination of pharmacy prescriptions. Subcontracting out any or all of these functions does not constitute actual performance or past performance history on the part of the prime contractor. Past Performance will be evaluated for the prime contractor and all proposed first-tier subcontractors.

Question 111. In pursuit of requesting completion of the Past Performance Questionnaire, how should the offeror proceed if they are told by an existing customer (i.e. Medicare) that their policy is to refrain from providing evaluations or similar reference surveys concerning the conduct or performance of any of its contractors? A similar situation may occur if a current customer decides there is a potential conflict of interest involved in providing a reference. Would it be permissible in such instances if the offeror provided the evidence of their best faith efforts in obtaining such documentation in lieu of a signed questionnaire from the customer?

Response 111. RFP Section L.9.2. requires the offeror to submit past performance data from each of its five largest current customers. The offeror shall provide this data, or if the customer refuses to provide the data, indicate this in the proposal, identifying the customer and the Point of Contact with contact information.

Question 112. The PDTS Interface Control Document section VII outlines Databases Eligibility. We assume all paper claim submissions will require enter data to be sent to PDTS which will initiate a DEERS query. (a) When a patient has a network claim processed on the same day a paper submitted claim with a different date of service will PDTS do a second query? (b) Will the government consider having the contractor query DEERS directly, if they have that capability, rather than sending DEERS queries through PDTS?

Response 112. (a) Each claim will be processed separately and for electronic claims an eligibility query will be completed. For paper claims, eligibility will be determined with the nightly demographic download from DEERS.

(b) No. Querying DEERS through PDTS is an integral part of the data collection process.

Question 113. The PDTS Interface Control Document page 72 discusses Reporting/Deliverables. This indicates PDTS will include TED Billing File records on the daily TED record on the 11th day. (a) Is this the day the PDTS will provide the demographic data to the TRRx contractor or the day the TED records are submitted to TMA? (see Section C.8.1) (b) Is the 11 day wait to process in-cycle reversals?

Response 113. (a) This is the day PDTS will submit the TED record to TMA. It will not be necessary for the demographic data to be passed to the contractor. This will be clarified via amendment.

(b) Yes.

Question 114. The PDTS Interface Control Document page 22 references OHI data. Will PDTS use the OHI information on DEERS or just from the MCSC's OHI data feed?

Response 114. Both.

Question 115. The PDTS Interface Control Document page 22 states regarding Deductible/Catastrophic Balances that the PDTS updates to the CC&D will be batch submissions until DEERS has a real time connection. During the time these DEERS transactions need to be batch. (a) Is a lock put on the Catastrophic Cap & Deductible record when PDTS queries DEERS for eligibility? If not, when does it take place? (b) When the lock query takes place what is the span of time when the update transaction takes place? (c) Once the update takes place is the record unlocked immediately? (d) If not what is the time span?

Response 115. (a) No. If the CC&D query indicates the beneficiary has not yet met their cat cap or deductible, the batch update will increment the file with the beneficiary cost. If the response indicates the beneficiary has met their cat cap or deductible, PDTS will flag the beneficiary's record to so indicate.

(b) The update is included in the batch file sent to the CC&D file.

(c) Yes.

(d) Not applicable.

Question 116. How will the Processed to Completion Date get populated on the PDTS generated TED records? Per the definitions in TOM (Appendix A) the Processed to

Completion Date is the day the checks and EOBs are prepared for mailing and the ADP history has been updated. There is no reference in the RFP in Section C to this issue.

Response 116. The processed to completion date is the date the prescription was filled and PDTS was queried and updated.

Question 117. Will the DoD Uniform Formulary be made available to the TRRx by start of healthcare delivery? If so, when will it be available for testing?

Response 117. Yes. A testing schedule to test all elements of the program will be established with the successful offeror following award. The current proposed rule is available through the Federal Register.

Question 118. In L.8.5.6.3 the government limits the number of PowerPoint slides submitted for oral presentations at 50. Will the government consider information submitted in the PowerPoint notes section of the slides if the contractor chooses to include information in the slide notes to clarify slide information?

Response 118. No. The slide consists of talking points which the offeror should address in its oral presentation.

Question 119. Section L sets the beginning period of evaluation of past performance information as January 1, 2000. Could TMA also establish an end date for this period? Without a finite period, the bidders could be faced with changes in the positioning of top five accounts or have large accounts terminate close to the date of submission date of the proposal and this would create an unreasonable burden on the bidder to make last minute changes in the submission in order to provide full disclosure. Any amendments delaying the submission date would exacerbate this difficulty. Consider this in addressing the requirements in L.9.5 and how this could affect the definition of "the last ten contracts not renewed".

Response 119. Offerors should provide the most current data available up to the date of proposal submission, without going back further than January 1, 2000.

Question 120. Since the TRRx contractor will be responsible for TED error correction and resubmission in specific timeframes, will the time be measured from when the PDTS notifies TRRx of the error and when they are sent back to TRRx? If not, are there specific standards imposed on the PDTS for timely transmission to TRRx of errors and relaying corrections to TMA?

Response 120. The contractor's clock for correcting data errors will start upon receipt of the error notice from PDTS.

Question 121. Will any other contractors be able to post Prior Authorizations or Medical Necessity Determinations on PDTS besides the TRRx? If so, who besides the TRRx? If

not, what is the purpose of making the TRRx use a third party to store their decisions to be used on for TRRx claim processing?

Response 121. Yes. The TMOP contractor will post PA and MN determinations to PDTS as will the direct care system. PDTS will flag all records with existing Prior Authorizations and Medical Necessity Determinations so as to avoid duplicate effort.

Question 122. Currently, one of the most urgent customer service situations that occur with network pharmacies under the current MCS contracts are when beneficiaries that need prescriptions immediately, are denied by network pharmacies based on OHI information that may be present on their files. If the beneficiary claims they have no OHI that covers drugs, the MCS contractor can, upon being contacted by their network pharmacy, can take the initiative to amend their file, so the patient may receive their drugs. The TRRx seems to have few options for this level of urgent response. In a similar situation C.9 of the RFP states the TRRx must obtain documentation from the beneficiary and submit this proof to the PDTS Customer Service Center. PDTS receives its file information from DEERS and DEERS information is obtained from MCS contractors in the new contractors. We also understand that when MCS contractors transmit information on OHI to DEERS, they may not have definitive information on the pharmacy coverage associated with that OHI. For instance, if an MCS contractor receives evidence of a commercial insurance plan paying for medical benefits, an OHI file may be built and an assumption may be made that the OHI covers drugs. Similarly, if the OHI is Medicare, the assumption may be made that the coverage does not include drugs. There are exceptions for both these assumptions, therefore the information on DEERS and ultimately PDTS could be incorrect. (a) Are there any provisions to accepting a beneficiary's statement that they do not have OHI covering prescription drugs especially under emergency situations or will these beneficiaries have to pay for their prescriptions and submit their documentation with a paper claim submission? (b) If the beneficiary states they have never had such coverage, what documentation will suffice? (c) Once the TRRx submits information to indicate the patient does not have drug coverage with their OHI, is it possible for MCS updates to DEERS OHI information to override this direction? (d) Is there a specific requirement in the T-Nex MCS contracts for the MCS contractor to collect information specific to OHI pharmacy since their jurisdiction does not entail processing pharmacy charges? (e) Are there any provisions for the TRRx or the PDTS for access to the Medicare Common Working File so they can determine participation in Medicare plans having pharmacy coverage?

Response 122. (a) On a case by case basis, beneficiaries may obtain an override for specific circumstances. Subsequently, beneficiaries must submit documentation, e.g., a letter, indicating that they do not have OHI with a pharmacy benefit, or that they have exhausted the pharmacy benefit under their OHI.

(b) Some form of documentation from the beneficiary stating they have never had such coverage.

(c) Yes, when the information from the MCSC more accurately reflects the OHI status for Pharmacy Coverage.

(d) The TRICARE Reimbursement Manual (Chapter 4, Section 3) requires Managed Care Support contractors to develop OHI to determine coverage limits.

(e) No.

Question 123. Please confirm that security requirements apply to ALL employees accessing Sensitive Information, not just IT/ADP employees.

Response 123. Confirmed. Any employee with access to data defined as "sensitive information" is covered by the Personnel Security requirements of the solicitation.

Question 124. Please confirm that the TRICARE Operations Manual (TOM) and its standards are NOT applicable to this procurement/contract as it appears since they are not included in Section J as the other T-Nex manuals are. If so, that conflicts with Carl's response to WPS that TOM Chapter 3 applies to Fiscal Controls for TRRx.

Response 124. The TOM is not incorporated into the TRRx solicitation. Fiscal controls for TRRx are specified in Section G of the solicitation.

Question 125. Please confirm that the Uniform Formulary will apply to both TMOP & TRRx and that it is the governments intent to administer them consistently between the two contractors.

Response 125. The Uniform Formulary, when published as a Final Rule, will apply to all points of service to include both the TRRx and TMOP contracts. Administration of each contract will be in accordance with the terms and conditions of each contract.

Q**uestion 126.** Please provide clarification of how Appeals will be handled when being sent to the "PRO". Will the entire file of information, including the Dr. records, be sent along with the previous Appeals decision?

Response 126. (Response added April 22, 2003) If the question is whether the complete file will be sent to the NQMC upon timely appeal of a medical necessity issue, the answer is "yes." Attachment 6, Section 1, paragraph 5.2. provides: "*When an appealing party files for a reconsideration with the NQMC, upon request of the NQMC, the contractor shall provide a complete file record to the NQMC*...." A "complete file record" is addressed in Attachment 6, Section 3, paragraph 4.5.1., where it is provided: "*All material related to the reconsideration shall be made part of the permanent claim file. The copy of the appeal file provided by the contractor to the NQMC or TMA must be complete, including the Appeal Summary Log (Addendum A, Figure A-2) and the Professional Qualifications form (Addendum A, Figure A-3)."*

Question 127. In reviewing the report requirements for Program Integrity (Attachment 11, Section J), we have interpreted that the quarterly fraud & abuse reports are summarized at the Contract Level. If not, what is the breakdown that the government proposes for these reports?

Response 127. We apologize for the confusion. The report breakdown is specified in Attachment 11, Section 4 and in Addendum A, Figure A-10, which was added by amendment.

Question 128. Section L.6 - 2.5 states that approximately 2.5 million beneficiaries are using the retail pharmacy system and that 8.7 million beneficiaries are eligible. Section C.4.1 states that we shall provide each beneficiary with a pharmacy card. Please clarify:

(1) Will the TRRx contractor mail:
a. a card to each eligible (8.7 million)
b. a card to only current users (2.5 billion)
c. a card to only households (no estimate, can the government provide?)
d. Would two cards per household be sufficient?

OR

(2) Can the government provide?
a. an estimate of on-going quarterly mailings expected each contract year?
b. How will this list be provided?
c. an estimate of the annual supply of cards needed by the MTFs and TSCs and other entities?

Response 128. The TRRx contractor will include the info card in the initial marketing package sent to the 2.5 million current users of retail pharmacy services specified in Section C.20.2. A card shall be sent to each individual user. The contractor must also ensure sufficient quantities are available to support the 8.7 million beneficiaries who may obtain a copy of the brochure or Info card at the TRICARE Service Centers, Military Treatment Facilities, or request a copy from the contractor. Approximately 50,000 new beneficiaries become eligible each month. This number may be 2-3 times higher during times of substantial Reserve call-up. This file will be provided quarterly via electronic media. Quantities for MTFs and TSC will be included in the MOUs with C&CS and the MCSC, but must support the total beneficiary population.

Question 129. Section C.8.1 states, "The demographic data from DEERS necessary to determine the appropriate bank account will be provided to the contractor two calendar days before PDTS submits the TRICARE Encounter Data (TED) record to TMA".

a. How will this information be provided to the contractor?

b. Will the data be in the NCPDP 5.1 format?

c. What data elements will be included?

Response 129. a. We have determined that it will not be necessary to provide the demographic data. This issue will be clarified via amendment.

b. Not applicable.

c. Not applicable.

Question 130. Please confirm that the TRRx contract will include today's TRICARE Pharmacy benefits as well as the TRICARE Senior Pharmacy (TSRX) benefits.

Response 130. Confirmed.

Question 131. Has TMA given any consideration regarding Program Integrity functions to be the responsibility of PDTS? The question is asked for the following reasons:

a) PDTS has the pharmacy data available and already has the capability of producing various reports that could determine aberrant behaviors on the part of providers and beneficiaries.

b) PDTS currently has a Program Integrity function that is staffed with personnel (former TMA investigator) that are familiar with investigations, case development, and referrals.

c) By utilizing the PI function already in place at PDTS, the overall costs to the government would be less.

Response 131. PDTS will perform Program Integrity functions in conjunction with the contractor's Program Integrity responsibilities. Primary responsibility for Program Integrity shall remain with the contractor.

Question 132. Does the government intend to allow beneficiary submitted claims for services at network pharmacies when TRICARE is the primary insurer?

Response 132. Yes. We expect these instances to be very few. They may occur in cases where communications between the pharmacy and the contractor or between the contractor and PDTS are not functioning.

Question 133. Does the government intend for the TRRx contractor to allow dispensing of non self administered medications such as chemo therapy or vaccines through the retail pharmacy network?

Response 133. Yes, non-self administered medications may be dispensed from a retail network pharmacy. The likelihood that chemo therapy or vaccines would be dispensed is remote.

Question 134. While it is understood that the MCSC jurisdictional restriction will go away under TRRX, the volume of paper claim projected in schedule B appears significantly lower (10 X) than what has been historically seen in the TRICARE business. The volume of paper claims resulting from Other Health Insurance alone may

exceed the Schedule B projections five fold. Could the government offer a explanation or describe the assumptions use for the paper claim projects?

Response 134. (Response added April 22, 2003) The Government has reviewed the projected volumes and revised them based on experienced data from March 02 through February 03. During this period, there were 828,875 paper claims with 3,398,216 prescriptions, averaging four prescriptions per paper claim. During this time period, there were 30,135,421 electronic claims. Approximately 10.13% of all prescriptions dispensed are submitted on paper claims. Further, approximately 2.47% of all claims are paper claims.

Question 135. The past performance requirements seem to vary. M.7.2 states "The government will evaluate past performance as it relates to the offeror fulfilling the functional requirements as stated in solicitation."

L9.1 states, "...in performing work as a Pharmacy Benefit Manager."
L.9.2 and L.9.3 also refer to past performance as a PBM.. If the contractor has experience in the functional requirement stated in Section C, such as Network, claims processing, Information Technology, Beneficiary Services, but not as a PBM, should they be included or is it the intent to limit past performance information provided to past performance as a PBM?

Response 135. The services referenced are all integral functions of a PBM operation. If an offeror has performed in these areas, they may be cited in support of an offerors past performance. Services performed in support of actual PBM operations will carry more relevance in the evaluation.

Question 136. Will past performance information involving functional requirements, not related to PBM services or operations be accepted?

M.7.3 states that failure to provide all reviews, etc...may have an adverse impact on the evaluation. Will past performance information involving other than PBM services be expected?

Response 136. The Government is primarily interested in past performance history relevant to providing PBM type services. If an offeror submits past performance history that is not relevant to providing PBM type services, it will not be considered in the evaluation.

Question 137. Section C.8.1 further states, " The contractor shall match the DEERS data to the claims records, and provide the account data back to PDTS to be included in the TED record within one calendar day of receipt of the demographic data".
a. What is the format that the contractor will use to supply this information to PDTS? b. Is it in the NCPDP 5.1 transaction format? c. Why can't the demographic data be sent with the initial PDTS POS transaction?

Response 137. This requirement has changed and is no longer applicable. It will be removed via amendment.

Question 138. Section C.8.2 states, "Claims for prescriptions filled but not dispensed (noncompliant) shall be reversed within ten calendar days of the date of the original claim was submitted".
Are you indicating that under no circumstances will it be possible to reverse a claim after ten days?

Response 138. No. The statement refers to the general requirement to have network pharmacies reverse filled prescriptions should those prescriptions not be picked up within 10 days of the original processing date. We recognize that circumstances may result in reversals beyond ten days.

Question 139. Section C.8.5 states, "For denied prescriptions, the contractor shall provide the pharmacy with the reason for the denial and an address and telephone number where the beneficiary may contact the contractor for additional information or appeal the denial in accordance with the requirements at C.16.3.4". We are assuming you are actually referring to claims which are rejected at the point of sale. Is this assumption correct?

Response 139. This requirement has been revised via amendment to allow NCPDP denial codes to be returned to the pharmacy. Contractor telephone numbers and addresses shall be listed on the information card required under C.4. to allow the beneficiary to contact the contractor to query the denial.

Question 140. Section C.14.4 describes the fact that the contractor will need to develop a system to exchange records directly with TEPRV.
Will the TEPRV (EIN+suffix) have to be included in the record to be supplied to PDTS?

Response 140. Yes. The contractor will crosswalk the NCPDP number to the EIN and provide to PDTS during the on-line claim submission.

Question 141. Section C.14.6.3 states, " the contractor shall execute the DITSCAP process by providing, for receipt by the Contracting Officer within thirty (30) calendar days following contract award...". Normally the contractor initially provides enough information to get an IATO. A full ATO requires that the contractor develop 20+ manuals (that have no commercial equivalent) to achieve a full ATO. It is our experience that this process cannot be done in 30 days.

Response 141. The contractor must provide all DITSCAP documentation within thirty days following contract award. TMA will provide DITSCAP documentation development templates to assist the contractor with the DITSCAP documentation development and will have DITSCAP subject matter experts available to provide additional DITSCAP documentation development guidance as required.

Question 142. Section G.1.1.3 states, "Upon processing a claim to completion, the contractor shall submit data to be used by the Pharmacy Data Transaction Service (PDTS) to generate a TRICARE Encounter Data (TED) record to TMA".

a. The standard NCPDP 5.1 transaction will contain the information required to complete the TED record.

b. Please refer to the PDTS TRRx Interface Control Document, referenced at Section J, Attachment 4. Section VIII (Transaction Submission) starting on Page 24 of that document outlines the required data elements needed for a successful transaction.

c. This is an on-line process.

Response 142. Requirement for connectivity with PDTS are defined in the PDTS Interface Control Document, referenced at Section J, Attachment 4.

Question 143. Section G.1.1.4 states, "PDTS will submit TED records to TMA on a daily basis, following a ten-day hold for each transaction". We are assuming that this ten-day hold is purposely "in-sync" with the ten-days for claims reversals.
a. Is this true?
b. If claims need to be reversed after, they are accepted by TEDS, can this be handled as an NCPDP reversal or does the contractor need to follow a recoupment process?

Response 143. a. Yes.

b. An adjusted TED will be generated and payment will be withheld from a future payment to the pharmacy.

Question 144. Section G.1.1.4 states, "The contractor must provide to the TMA/CRM Fund Certification Officer by e-mail or other agreed upon method, the total amount of payments by bank account and all TED voucher numbers being paid...". Since the contractor has no access to the TED system, how does the contractor get the "TED voucher numbers"?

Response 144. PDTS will provide a copy of the TED data to the contractor at the same time the TED records are submitted to TMA.

Question 145. Section G.2.2 states, "The ICN is the unique number assigned by PDTS to each transaction record".
a. When will the ICN number be assigned by PDTS?
b. Will this be done during the point of sale process or during some other process? c. Will the ICN nuber be used to determine timeliness? d. If not, then how will timeliness be determined?

Response 145. a. The ICN will be assigned at the time the TED record is generated.

b. See previous response.

c. No.

d. The contractor is required to meet the processing time requirements specified in Section C.8.8.. Since timeliness will be tracked via the contractors information system, specific methods for monitoring will be determined after contract award with the contractor and incorporated into the Government's surveillance plan.

Question 146. Section G2.1 states, "PDTS generates a TED record for each prescription filled and for each Prior Authorization and for each Medical Necessity Determination completed".
a. Is the Prior Authorization and Medical Necessity transaction a separate transaction from the NCPDP 5.1 claims transaction? b. If so, please detail the format and method of exchange with PDTS?
c. How will the ICN number be generated for these Prior Authorization and Medical Necessity transactions?

Response 146. a. Yes.

b. Prior authorization and medical necessity will be entered by the Contractor and submitted to PDTS using SelectRx software. The Contractor will be provided the software and trained in the use of that software at Government expense. This is an on-line process.

c. The ICN will be issued at the time the TED is generated.

Question 147. Section L.8.2 states, The contractor will need to identify the number of eligible beneficiaries who will have to change pharmacies in order to minimize the impact of any disruption or inconvenience caused by changes to the network structure". Does the government mean unique utilizers instead of eligible beneficiaries?

Response 147. Thank you, you are correct. This will be changed via amendment.

Question 148. Section L.8.2 states, "the government requires the contractor determine the number of unique utilizers that will be displaced because of its network structure". Does the government take into account that the contractor's network structure may displace a high number of low utilizers while it provides adequate coverage for all high utilizers thus having a minimal overall impact?

Response 148. Please clarify. The Government does not intend to provide data regarding the amount of utilization by beneficiary. Offerors are reminded that they must meet the minimum network access standards, while minimizing disruption to beneficiaries.

Question 149. The government describes several data exchanges such as DEERS demographic data exchange, Bank Account Claim data exchange, Funding Assurance transmission, Payment Amounts & TED Voucher Number transmission, ad Payment Issued & Amounts transmission. Please provide transmission mechanisms, (through PDTS or some other entity) and the data formats (layouts) for each interaction.

Response 149. All data transactions are specified in the PDTS Interface Control Document at Section J, Attachment 4, or in the TRICARE Systems Manual at Section J, Attachment 5.

Question 150. As far as DoD interoperability, are you considering the use of smart cards and PKI? Are you open to that? Can we make an offer for that?

Response 150. While not a requirement, the use of smart cards and PKI could be considered as a means to meet the DITSCAP requirements. The use of smart cards in retail pharmacies is not standard commercial business practices and therefore not a requirement.